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HOSPITAL SHIPS MEET BIGGEST CHALLENGE EN ROUTE TO GULF

-- Story and Photos by PHC Carolyn E. Harris, USN

Eight days after Iraq invaded Kuwait, hospital ship USNS Mercy (T-AH 19) and her sister ship USNS Comfort (T-AH 20) were activated as part of Operation Desert Shield. At that time USNS Mercy, homeported at Oakland, Calif., was on reduced operating status with a military cadre crew of forty medical and support personnel. When the ship sailed six days later, the crew had grown to almost a thousand Navy men and women.

From the first day of activation, these men and women were in a race against time. They had a month--the time it took them to reach the Arabian Gulf--to prepare the world's largest trauma center.

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"Normally it takes five days to get ready," said Captain Dan O'Brian the man chosen by the Military Sealift Command to be the civilian master of the ship. "The ship had just off-loaded most of its fuel in preparation for a refit, so it took us an extra day to get ready. There were already plans drawn up on what to do to activate the ship. I just made sure everything was done that needed to be done."

While Captain O'Brian and a crew of additional civilian mariners were getting the ship ready to sail, Captain Paul D. Barry, a Navy doctor and the newly appointed Commanding Officer of USNS Mercy Medical Treatment Facility, was working with the cadre getting the nearly one thousand new people on board.

The crew, consisting of medical and support personnel, was drawn from over thirty shore installations, detachments, Marine Corp bases, Navy ships and a submarine. Most of these doctors, nurses, hospital corpsmen, personnelmen, yeomen, disbursing clerks and every other rate needed to run a U.S. Navy noncombatant had less than the allotted five days to say good-bye to their families, settle their personal affairs and report aboard. Almost half of the crew were women.

"USNS Mercy is no longer an extension of Oakland Naval Hospital," said Barry, who, from the start, nurtured the esprit de corps of the crew and promoted the pride of mission that everyone on the ship developed over the weeks and months that followed.

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Many of the new crew were volunteers. One of them, Navy Chief Hospital Corpsman Terisa Leal, didn't even have the luxury of spending the last few days before deployment with her husband and two young sons. Leal, who worked at the Naval Supply Center, Oakland, was the medical liaison for the Western Pacific when she reported for duty on USNS Mercy. She and others newly assigned to the ship's supply department worked around the clock ordering and loading supplies during the five days prior to sailing.

"The hardest part was trying to figure out working relations with people you didn't know," said Leal. "We became a team out of necessity. We didn't know people's names or where they came from.

"We had to figure out what supplies we had, where they were, and where they were suppposed to go. What supplies we didn't have, we had to do the documents for, feed them into the system and wait for deliveries.

"The amazing thing was how rapidly the system worked in a crisis.

"We put in requisitions through the supply system and companies in the Bay Area were delivering the same day. The Sunday night before we sailed, we unloaded five 'semi-trucks' on to the ship's flight deck. It was only later that I learned the full names of every one I worked with and where they came from."

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The supply people weren't the only ones working round the clock. The crew needed training. Organizing and planning that task became the responsibility of another volunteer crew member, Lt.Cmdr. Carol Bohn, a Navy nurse and head of Command Education Department at Oaknoll Naval Hospital in Oakland.

"I've wanted to go to sea all my life," said Bohn. "If they didn't take me, I told them I would swim in the wake of the ship. I knew that training would be a top priority and it seemed logical, especially in the short turnaround time, that the people who know training best would be the most logical people to go.

"The biggest challenge we faced was to get a large volume of complex new information to an already stressed crew in a constructive way. What was in our favor was the urgency of the mission."

During the one-month transit to the Gulf, the crew, many of whom had never been to sea and most of whom had never treated combat injuries, needed training to work together as a cohesive unit. Lt.Cmdr. Allison Mueller, a Navy nurse who worked with Bohn at Oaknoll Naval Hospital, came off sick leave and postponed her retirement to a farm in Kansas when she found out that the USNS Mercy was being activated. Mueller, who had close to two decades of experience as a Navy nurse, teacher and expert in emergency medicine, was instrumental in developing Mercy's realistic training program.

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"I was assigned to Oaknoll Naval Hospital during my first tour in the Navy," Mueller said. "We were still receiving wounded from Vietnam at that time. I also helped treat the POW's when they came home. Whenever I met medical people who had been in Vietnam I grabbed hold of them and asked them questions. I've been trained by the best. Since 1982 I've been involved with teaching EMT -- Emergency Medical Treatment."

Many of Mueller's former students are hospital corpmen assigned to Marine units that were deployed to the front lines of operations Desert Shield and Desert Storm.

The most sobering class Mueller taught was Introduction to Combat Medicine. The class was mandatory for all hands, including non-medical personnel. Although not involved with the direct medical treatment of patients, many of the personnelmen, disbursing clerks and yeomen on board were trained as litter bearers and were on the decontamination teams.

In this class, Mueller gave statistical evidence--gleaned in the aftermath of the last three wars fought by American servicemen--of the type of combat wounds and injuries that USNS Mercy was expecting to receive. These statistics were reinforced with color slides of actual injuries suffered by the men who served in Vietnam.

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"I wanted them to know what to expect, said Mueller. "I wanted them to know the intensity and the urgency of the situation -- that real people die. The harder we train the less chance of loss of life because of inexperience or because people didn't know what to expect."

Other mandatory classes stressed shipboard and flight-deck safety. The entire crew was measured and fitted for MOPP (mission-oriented protection posture, a type of clothing designed to protect the wearer from poison gas attack) suits and issued gas masks, which they learned to don in less than nine seconds. All crew members were trained in how to use auto-injectors of atropine and its antidote, pralidoxime chloride. They carried these chemicals in their gas mask containers under orders to use them only by direction of the commanding officer. To reinforce the classroom training, ship-wide mass casualty drills were meticulously planned, executed and later analyzed.

Cmdr. Henry Rosas, head of thoracic surgery was selected to develop the casualty flow plan and with Cmdr. Alicia Deprima, a Navy nurse, established the trauma team program.

Rosas, who acquired extensive first-hand knowledge of battlefield medicine as a field corpman with the Marines in Vietnam, was in charge of patient triage.

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Rosas, Bohn and Mueller met with the different medical specialists and department heads several days before the drill to develop a scenario of each type of casualty sent through the treatment process.

The drills were not to test the medical knowledge of the doctors, nurses or corpsman. Their purpose was to get everyone used to working to together. Time is critical in the treatment of the wounded. They wanted to know how long it would take to get a neck brace if a doctor ordered one, how long for a blood test. Where could they cut corners in paper work.

Hours before the drill began, volunteer "patients" reported to a passageway just off the flight deck. Mueller, Bohn or one of the other people they have trained made-up the patients to match the injury they were assigned. This was done with specially designed moulage kits brought on board by the training team. The patient was then briefed on how to act for each injury, for example: a patient with burns from an explosion may have been told to collapse to simulate an undiagnosed head injury. The realism of the wounds was unsettling to the non-medical personnel. A liver protruded from a belly wound on a patient. A trip to the chow hall on board before the exercise provided Mueller with a piece of calve's liver used as a training aid.

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The first casualty drill had only five patients. Eventually 80 patients were treated by Mercy personnel during the same amount of time. Once the patients were made up, the first group of injured were taken to the center of the flight deck. Stretchers were arranged in a tight pattern on the flight deck. The drill was called.

Flight deck crew members were dressed with life vests over vividly colored jerseys. Cranials covered their heads and all safety standards were rigidly observed. This was the most dangerous place on the ship. No short cuts were allowed for the sake of saving a few seconds. The flight deck crew chocked and chained an imaginary helicopter.

Teams of stretcher-bearers lined up at the edge of the flight deck dressed to the same safety specifications as the flight deck crew. Wearing a bright yellow jersey, Chief Frank Alioto, an aviation boatswains mate, directed a team of four stretcher bearers around the imaginary helo to the patients. The four men and women moved at his direction, crouching low to avoid the imaginary rotor blades. The patients were then quickly taken inside the skin of the ship to a bank of elevators and gently set down. Then their injures were quickly checked by Dr. Steven Metz, a surgeon/gynecologist. Metz gave orders as to who was to be taken off the elevator first. A small team of corpsmen, trained in emergency medical techniques, stood by ready to give Dr. Metz an assist with any of the patients if he needed it.

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The casualties were loaded on the elevators, which could take six stretcher patients at a time. Within seconds the wounded were whisked down to casualty receiving, an area similar to a vast emergency room there they were met by Dr. Rosas and Cmdr. Linda Klammer, a nurse, who triaged the patients.

Nearby, in close communication with Rosas, Dr. Robert Abbe, head of surgery, dispatched a team of surgical specialists to patients that were identified as needing immediate surgical intervention. Stretcher-bearers transported patients from the elevator to waiting gurneys. Each patient was quickly examined by Dr. Rosas as Cdr. Klammer made quick notes on a clip board. Names were taken from dog tags and a corpsman from patient administration quickly completed the narrow plastic identification bracelet and admissions documents. After the patient was evaluated he or she was wheeled to one of the 12 patient-care teams.

Physically the casualty-receiving area was broken into three areas. Those patients needing immediate intervention or resuscitation were sent to one of five teams. The teams consisted of two nurses (one designated team leader) and four corpsman. The patient was accompanied by the surgeon specialist, such as a neurosurgeon, if the patient had a head-wound. Each of the teams had responsibility for an area that had three gurneys.

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Advanced Trauma Life Support (ATLS) protocols were followed, with the goal being to stabilize patients prior to transfer to the next area of care, usually to one of the twelve operating rooms that the USNS Mercy has or to the Intensive Care Unit. Ideally, the patient would only stay in the casualty receiving area from 30 to 45 minutes. The X-ray Department was located next to casualty-receiving and the operating rooms right next to X-ray. If the patients needed intermediate care, they were wheeled to another area of casualty-receiving where there were an additional five teams standing by. Teams on this side received trauma patients but usually none requiring immediate operative intervention. One of the teams on this side had been designated as the primary area for burn victims, with a burn cart located there.

According to Klammer, training was intense for the people assigned to casualty receiving. "Most of the nurses who worked there have prior training and experience in critical care or emergency medicine," she said. "While we were on the ship we had classes in BCLS (basic cardiac life support), ACLS (advanced cardiac life support) and ATLS.

"There is no real substitute for a real patient, but the drills help."

Casualties that were "gassed" required special treatment. They had to pass through a decontamination process before being sent to casualty-receiving.

They were taken to a specially designed area just off the flight deck to waiting personnel who were trained in decontamination. These personnel wore MOPP gear and cut the clothes off of the contaminated casualties. The casualties were then taken into a room lined with stainless steel and laid in a long stainless steel sink. Two decontamination team members washed the casualty with a solution of ordinary household bleach to neutralize the gas droplets on the skin. The bleach solution was then hosed off with plain water and the casualty was transferred to another room were his injuries were checked and evaluated. He or she was then sent to a special section of casualty-receiving set aside for people who had been gassed.

Casualties that required surgical intervention were sent to the operating room accompanied by a surgeon or surgeons and an anesthesiologist. The operating rooms on USNS Mercy are larger than ones normally found in hospitals ashore. Very often more than one organ system is involved in a combat trauma. A casualty may have a head injury requiring surgery by a neurosurgeon and have a leg injury requiring an orthopedic surgeon. The size of the operating rooms allowed for two teams of surgeons to work on one person at the same time.

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Eighteen surgeons sailed with USNS Mercy. They were capable of performing all types of surgery except open heart. There was no heart-lung machine on board. Expecting all types of injuries, the surgical specialists included Captain Robert Cave, one of the Navy's most experienced plastic surgeons, and Captain Ben Ho, a surgeon/ophthalmologist who is a specialist in treating eye injuries with lasers.

"Our priority was to save life and limb and to return the patient to full function as soon as possible," said Klammer, explaining the triage system that USNS Mercy used. "I want to stress that any patient that came to us was treated. Triage just means sorting."

Once USNS Mercy reached the Persian Gulf, it was visited by Army General H. Norman Schwarzkopf, Operation Desert Shield/Storm Commander-in-Chief. Speaking to the crew of USNS Mercy, Gen. Schwarzkopf recalled his experience as commander of all land forces during the Grenada exercise. He felt that the medical capabilities were inadequate for the amount of casualties suffered by U.S. troops.

"That is something we should never, never, never do to the men and women in our armed services," he said. "They don't mind coming out here, and they don't mind serving their country.

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"They do expect two things: Number one -- they expect the support of the folks back home. Number two -- they expect that if anything happens to them while they're out here, they're going to be well taken care of.

"That's exactly why you are all here. God willing, you will never have to use the skill that you all have. But if the time comes when you will have to practice those skills, we're going to desperately need your help."

Fortunately, there were relatively few allied casualties of the Gulf war. But the possibility of thousands put the pressure to be prepared on the crews of Mercy and Comfort.

Constant training enabled the hospital ships to meet the challenge.

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